

# **OAT Rural Telemedicine Grant Program FY2000**

## **GRANT APPLICATIONS WILL BE RETURNED IF...**

any of the following **errors** are discovered:

- **Deadline Missed:** Official Postmark or Receipt dated after 3/15/2000 (applications must be received in a timely manner to be reviewed);
- **Not adhering to specified page limitations or formatting requirements;**
- **If the two required rural spoke sites do not meet the rural criteria specified in the application kit;**
- **Applicant is not a public (non-Federal) or non-profit entity.**

(Reference: For detailed explanation on all the above eligibility requirements, please refer to the Office for the Advancement of Telehealth (OAT) Program Guide or call OAT at 301-443-0447.

# **RURAL TELEMEDICINE GRANT PROGRAM**

**Catalog of Federal Domestic Assistance Number 93.211**

## **PROGRAM GUIDE** **FY 2000**

### **OFFICE FOR THE ADVANCEMENT OF TELEHEALTH**

**Health Resources and Services Administration  
Public Health Service  
Department of Health and Human Services**

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## INTRODUCTION

This Program Guide outlines the requirements and guidelines for the Rural Telemedicine Grant Program. Prior to preparing the application, applicants should be thoroughly familiar with this *Program Guide*, the *PHS Grant Application – Form PHS-5161-1*, and the *Supplemental Instructions to PHS Grant Application-Form-PHS-5161-1*.

The Rural Telemedicine Grant Program described in this Program Guide is authorized by Section 330A, Title III of the Public Health Service Act, as amended by the Health Centers Consolidation Act of 1996, Public Law 104-299.

As amended, Section 330A of the PHS Act, authorizes the Rural Health Outreach, Network Development and Telemedicine Grant Program. Grants supported under this program are to "expand access to, coordinate, restrain the cost of, and improve the quality of essential health care services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions". Two approaches to achieve these goals are through projects funded by the Office of Rural Health Policy under the Rural Health Outreach and the Rural Network Development Grants Program. A third approach is through projects funded by the Office for the Advancement of Telehealth under the Rural Telemedicine Grant Program.

The Catalog of Federal Domestic Assistance Number for this grant program is 93.211.

## PURPOSE OF PROGRAM

The Rural Telemedicine Grant Program has one primary objective: to demonstrate how telemedicine can be used as a tool to a) improve access to health care for rural individuals across the life span, b) reduce the isolation of rural practitioners, and c) foster integrated systems of care. A secondary objective is to collect data and information for the systematic evaluation of the feasibility, costs, appropriateness, and acceptability (to practitioners and patients) of telemedicine technologies and services in rural communities. The systematic evaluation of telemedicine is necessary to determine how best to organize and provide telemedicine services in a sustainable manner.

Integrated systems of care foster comprehensive, coordinated health care to the rural residents served by the system. They do so by providing referrals, consultations, and support systems that ensure patient access to a comprehensive set of health services across levels and sites of care. They also foster more effective, efficient delivery of health care services both by linking scarce resources at the local level and by facilitating the sharing of resources between rural and urban health facilities.

## ADMINISTRATION AND ASSISTANCE

The grant program described in this *Program Guide* is administered by the Office for the Advancement of Telehealth (OAT), Health Resources and Services Administration (HRSA).

Applicants may obtain programmatic information and technical assistance by contacting the following OAT staff:

Cathy Wasem or Amy Barkin  
Office for the Advancement of Telehealth  
5600 Fishers Lane, Room 11A-55  
Rockville, MD 20857  
Phone: 301-443-0447  
FAX: 301-443-1330  
Internet: cwasem@hrsa.gov  
abarkin@hrsa.gov

Information and technical assistance regarding business, budget or financial issues of the proposed project should be directed to the following staff member of the Office of Grants Management, Bureau of Primary Health Care, HRSA:

Martha Teague  
Grants Management Office  
Bureau of Primary Health Care  
West Tower, 11th Floor  
4350 East West Highway  
Bethesda, MD 20814  
Phone: 301-594-4258  
Fax: 301-594-4073  
Internet: mteague@hrsa.gov

## **ROLE OF STATE OFFICES OF RURAL HEALTH**

Early in the process of developing a proposal, an applicant is required to notify its State Office of Rural Health (or other appropriate state entity) of its intent to apply for this grant and to consult with the State Office regarding the content of the application. State Offices may be able to provide information and technical assistance. The applicant should specifically inquire how their proposed activities would relate to any rural health planning activities being funded under the Rural Hospital Flexibility Program (RHFP). To the extent that an applicant can coordinate its activities with the RHFP, they should do so. A list of State Offices of Rural Health is included in the application kit. It is also available on the web at: <http://www.nal.usda.gov/orhp/50sorh.htm>

## **FUNDS AVAILABLE AND FUNDING REQUIREMENTS**

Approximately \$ 5 million is available for the Rural Telemedicine Grant Program in FY 2000. The Office for the Advancement of Telehealth expects to make 12-15 new awards.

### **Size of Awards**

- Individual grant awards under this notice will be limited to \$375,000 (including direct and indirect costs) per year for start-up networks and \$325,000 for existing networks. (It is anticipated that an existing telemedicine network would already be supporting personnel at

the hub site and have some equipment. If an existing network will not be implementing new clinical services, but only expanding current services to new sites, it is anticipated that this also would be reflected in a lower funding request.) Overall, applications for smaller amounts are strongly encouraged.

#### Duration of Funding

- Applicants should propose project periods for three years. However, applicants are advised that continued funding of grants beyond FY 2000 is subject to availability of funds and grantee performance. No project will be supported for more than three years. The budget period for new projects will begin September 1, 2000.

#### Use of grant funds

- Grant funding must be used for services provided to or in rural communities. Fifty percent (50%) or more of the grant award must be spent for: costs incurred in rural communities, including rural staff salaries and equipment maintenance; equipment placed in rural communities, irrespective of where the equipment was purchased; and transmission costs and clinician incentive payments.
- No more than forty percent (40%) of the total grant award each year may be used to purchase, lease or install equipment (i.e., equipment that is used inside the health care facility for providing telemedicine services such as codecs, multiplexers, monitors, cameras, computers, etc.). Moreover, of this 40%, no more than 35% or \$50,000 (whichever is higher) can be spent for equipment whose sole use is teleradiology.
- Grant funds may not be used to purchase or install transmission equipment, such as microwave towers, digital switching equipment, amplifiers, or laying cable or telephone lines.
- Grant dollars may not be used to build or acquire real property, or for construction or renovation, except for minor renovations related to the installation of equipment. Minor renovations might include adding electrical wiring or installing shelving and cabinets. Building a new room, or completely remodeling a room for the telemedicine system would not be considered a minor renovation.
- Grant dollars may not be used to support didactic distance education activities. However, equipment purchased to provide clinical services may be used for a variety of non-clinical purposes, including didactic education, administrative meetings, etc.

Grant dollars may not be used to cover the transmission costs or clinician incentive payments for out-of-network sessions.

- Grant funds may be used to support the operating costs of the telemedicine system, including compensation payments for consulting practitioners and referring practitioners.
- If OAT funds are used for clinician incentive payments, payments can be up to a maximum of \$75 per practitioner per telemedicine session/encounter per site. Practitioners can include

a range of health professionals (e.g., physicians, dentists, nurse practitioners, physician assistants, clinical social workers, clinical psychologists, speech therapists, dieticians, etc.).

- If a third-party payer, including Medicaid and Medicare, can be billed for a consult, the grantee may not provide the practitioner with an OAT-funded incentive payment. This requirement applies even if the grantee has not yet established its own internal procedure to bill Medicaid.
- Grant dollars may be used to pay for transmission costs, such as the cost of satellite time or the use of phone lines. However, applicants who are eligible must apply for the Universal Service program to lower transmission rates or provide a rationale for why they are not applying (e.g., if they believe the Universal Service subsidy would not lower their rates, this must be demonstrated). For additional information about the Universal Service Rural Health Care Provider program see the Universal Service Administrative Corporation (USAC) Web site (<http://www.rhc.universalservice.org>).
- Grant dollars may be used to support the development of a business plan. The applicant will be required to submit a detailed business plan as part of its Year 2 non-competing continuation application, which is due in the ninth month of the first year.

#### Indirect Costs

- In accordance with the law, no more than 20 percent of the amount provided under a Rural Telemedicine grant can be used to pay for the indirect costs associated with carrying out the purposes of such grant. For an organization with a Negotiated Indirect Cost Agreement with a cognizant Federal agency, said agreement will be used to determine reimbursement of indirect costs (up to the 20 percent limitation *calculated on the total Federal award*). A copy of the most recent agreement must be provided and must contain a "services" or "all other programs" rate. A rate negotiated for **research** programs is not acceptable for this grant program.

If an applicant does not have a negotiated indirect cost rate agreement, it cannot claim indirect costs. All costs must be direct.

If the applicant does not have a negotiated "service" or "all other programs" rate with a cognizant Federal agency, or if it only has an indirect cost rate for research programs, the applicant should contact the grants management office identified in the program announcement for information on a contact point to assist in the development of such a rate.

#### Cost participation

- Cost participation serves as an indicator of community and organizational support for the project and of the likelihood that the project will continue after federal grant support has ended. Applicants and **each** OAT-funded network member are required to demonstrate cost participation. Cost participation may be in the form of cash or in-kind (e.g., equipment, personnel, building space, indirect costs). (Cash and other in-kind contributions should be included on the budget forms and in the narrative budget justification). There is no required amount of cost participation; however, applicants are reminded that the extent of cost participation is a component of a review criterion.

If an award is made, all funds identified as dedicated to this project (including funds used for cost participation) will be subject to the applicable cost principles, audit and reporting requirements.

## DEFINITIONS

For the purposes of the Rural Telemedicine Grant program, the following definitions apply:

**Budget Period:** the interval of time into which the project period is divided for budgetary and reporting purposes. For this grant program, the time interval is 12 months.

**Interoperability / Open Architecture:** the condition achieved among telecommunication and information systems when information (i.e., data, voice, image, audio or video) can be easily and cost-effectively shared across acquisition, transmission, and presentation technologies, equipment and services. It is facilitated by using industry standards rather than proprietary standards.

**Multispecialty Entity:** an entity that is capable of providing 24-hour-a-day specialty consultations to rural sites using telecommunication and information technologies (e.g., a tertiary care hospital, a multispecialty clinic, or a collection of facilities that, combined, could provide 24-hour-a-day specialty consultations).

**Presenter:** A health professional who is responsible for presenting a patient to a consulting provider(s) during a telemedicine clinical session/encounter. Although the presenter may be the referring clinician, in many telemedicine projects, presenters are specially trained nurses or other telemedicine team members.

**Project Period:** the total time for which federal support of a discretionary project has been approved. A project period may consist of one or more budget periods. For this grant program, the project period will generally consist of three budget periods.

**Rural:** a site that meets one of the following two criteria:

(1) located outside of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget (OMB). (A list of counties that are designated as being non-MSA or 'rural' counties is provided in this application kit – see "Rural Counties by State" list. The list is also available on the following Web site: (<http://www.nal.usda.gov/orhp/rurcties.htm>)

**OR**

(2) located in one of the specified rural census tracts (CTs) or block numbered areas (BNAs), of an MSA county, as defined by the Goldsmith Modification. Although such counties are classified as MSAs, or part of an MSA, large parts of these counties are rural. The names of these metropolitan counties are included in the 'Rural County' list provided in the application kit. See the key at the bottom of the "Rural Counties" list for directions on how to interpret the contents of the list. The MSA counties with rural census tracts are listed on the Web site provided in #(1) above. Also enclosed in this packet is a list of Census Bureau Regional Offices to help an applicant determine a site's census tract number. Facilities located in these rural census tracts are eligible for the program.

**Rural Primary Care Practitioner:** a physician, nurse practitioner, physician assistant, or nurse-midwife providing primary health care services whose office or clinic is located in a rural area as defined for this grant program.

**Telemedicine:** the use of telecommunication, information, and health status monitoring technologies for clinical care of patients. OAT includes in this definition, patient counseling, case management, and supervision/preceptorship of rural medical residents and health professions students when such supervising/precepting involves direct patient care.

The definition does not include the use of telecommunication and information technologies for didactic distance education, such as lectures or other programs designed solely to instruct health care personnel, health profession students or patients. OAT grant dollars cannot be used to support such activities, although equipment purchased to provide clinical services can be used for a variety of non-clinical purposes, including didactic education, administrative meetings, etc.

**Telemedicine Clinical Session/Encounter:** a person-to-person interaction relating to the clinical condition or treatment of a patient. It is the process by which a clinical service is delivered. The session may be interactive (i.e., in real-time) or asynchronous (i.e., using store-and-forward technology).

Examples of sessions include, but are not limited to the following: an interaction between two practitioners, with or without the patient present, regarding the diagnosis and/or treatment of the patient; an interaction between a specialty practitioner and a patient; a session involving two interdisciplinary health care teams with or without the patient and patient's family present; a session between a home care health professional and an individual in the home; an interaction between a practitioner and a student in elementary or high school.

Professionals from a variety of health care disciplines may be involved in requesting and/or providing telemedicine sessions/encounters including, but not limited to: physicians, physician assistants, dentists, dental hygienists, nurses, nurse practitioners, nurse-midwives, clinical nurse specialists, physical therapists, occupational therapists, speech therapists, clinical psychologists, clinical social workers, substance abuse counselors, podiatrists, optometrists, dietitians/nutritionists, pharmacists, optometrists, EMTs, etc.

**Telemedicine Network:** a telemedicine network is comprised of hubs (i.e., entities whose health care professionals provide consultations or whose faculty supervise or precept health professions students for clinical care in rural facilities) and spokes (i.e., entities whose professionals and/or patients receive consultations).

Some entities may function as both a hub and a spoke. For example, as a "spoke", a physician in a rural hospital may receive consultations from a multi-specialty clinic, and as a "hub", the physician may provide consultations to a physician assistant in a remote rural clinic. Likewise, health care professionals in a small rural hospital may receive consultations from a tertiary care center and provide consultations to health professionals in a rural nursing home.

Rural spokes may be health care facilities or places in which health care is provided, such as schools and homes. Examples of spoke sites include rural hospitals, clinics, nursing homes, mental health centers, public health clinics, schools, homes, assisted living facilities, senior citizen housing, centers for the developmentally disabled, rehabilitation facilities, etc.

The network may have additional members who do not directly receive or provide consultations, but who foster access to and coordination of services, such as area agencies on aging, school systems, providers under the WIC program, or other.

Spoke sites may also be able to connect to other tertiary consulting hubs, specialists or spoke sites not part of the applicant telemedicine network, because of the ability to dial-out to sites. However, for the purposes of this project, these other sites would not be considered part of the network, nor would the consulting specialists at the non-network sites have access to the OAT clinician incentive payments.

## **PROGRAM REQUIREMENTS**

### **Telemedicine Network**

In order to compete for this grant program, an applicant must participate in a telemedicine network that includes at least three members: (1) a multi-specialty entity (hub) that is located in an urban or rural area, which can provide 24-hour-a-day access to a range of specialty health care; AND 2) at least two rural health facilities (spokes), which may include small rural hospitals (fewer than 100 staffed beds), rural physician offices, rural health clinics, rural community health clinics and rural nursing homes.

A telemedicine network is characterized by a partnership among all members that is evidenced by:

- **Resource contribution by each member** -- each member brings resources (e.g. money, space, staff, etc.) to the partnership to enable the network to accomplish its mission.
- **A specified role for each member** -- each member has a clearly defined role in the network and a specific set of responsibilities for the project.
- **Active participation of each member** -- each member participates in the planning and implementation of the telemedicine project.
- **A long-term commitment to the project by each member** -- each member demonstrates a method for sustaining the activities of this grant project when OAT funding end.
- **A clearly articulated relationship** -- each member has signed and dated a memorandum of agreement that delineates the specific role and resource contribution of the member and delineates equipment placement decisions and maintenance responsibility during the project and when OAT funding ends.

### **Telemedicine Clinical Services**

As a means to increase access to care and foster system sustainability, OAT is interested in the utilization of telemedicine systems for a variety of clinical services provided by professionals from

different health disciplines. A few examples of clinical services are: cardiology, dental, dermatology, home care, geriatric, mental health, neonatology, neurology, nutritional counseling, obstetrical/gynecological, oncology, orthopedic, pediatric, pharmacy, physical therapy, speech pathology/therapy, wound care services, etc. (This is not a comprehensive list of the types of clinical services that could be provided by a telemedicine network; it is provided only as an example of the types of services that might be provided).

Some clinical services can be provided by different health professionals (e.g., mental health services are provided by psychiatrists, social workers, psychologists, mental health nurses, family and marriage counselors, and other trained behavioral health specialists; cardiology services may be provided by a cardiologist or a cardiac clinical nurse specialist; home care services might be provided by a nurse, a social worker, a physical therapist, an occupational therapist, etc.; geriatric services may be provided by an interdisciplinary team composed of geriatricians, social workers, pharmacists, gerontological clinical nurse specialists, dietitians, psychologists, and physical therapists).

Applicants must meet the following programmatic requirements for clinical services:

- 1) A minimum of eight (8) clinical telemedicine services must be provided over the network by the middle of the third project year. By the end of the first year at least two services must be provided, by the end of the second year an additional three services must be provided, and by the middle of the third year all eight services must be provided. For existing programs, it is anticipated that they may be able to implement all 8 clinical services within a shorter period of time. Not all services need be provided to all sites and each service need not be provided across the life span.
- 2) At least two of the clinical telemedicine services provided by the network with OAT funding must be provided by physician.
- 3) All services must be based upon documented needs of the rural community(ies) and/or population groups to be served. Where possible, applicants should demonstrate that the services proposed reinforce existing referral patterns.
- 4) All services provided with funding from this grant program must be available from the hub on a 24 hour-a-day basis. Applicants must provide assurances (e.g. signed, dated memorandums of agreement) that the services will be available 24-hours-a-day. If a service will not be available 24 hours-a-day, the applicant must justify not providing it on that basis (e.g., physical therapy services are not typically provided on a 24-hour basis). An entity is considered capable of providing consultations on a 24-hour basis if it has specialists on call.

If the practitioners who are to provide consultations are not employees of one of the network members, they must sign a separate memorandum of agreement (MOA) and it must be included in the application. For example, if the psychiatrists who will be providing mental health services for the telemedicine network are not employees of the multi-specialty entity, but rather belong to an independent practice group, a signed MOA from the practice group or the physicians involved is required.

Applicants that are not multi-specialty entities are strongly encouraged to have signed contracts with the multi-specialty site member(s) or other appropriate network members, assuring that the services will be provided.

Applicants should also submit assurances signed by the rural health professionals who are expected to use the telemedicine system to refer patients to specialists and/or participate in sessions/encounters, indicating their desire and intent to do so.

## System Design

OAT believes that e-mail and health information services/systems enhance the ability of telemedicine network members to efficiently communicate, schedule consultations, and share health information for care and administrative purposes. Therefore, all members of a telemedicine network funded under this grant program will be required to be electronically linked, for at least e-mail services, by the ninth month of the first budget period. They will also be required to demonstrate how they plan to link the telemedicine system with their institutions' health information systems by the 24<sup>th</sup> month of the project (i.e., by the end of the second year).

Whenever possible, telemedicine systems should be designed using standards-based equipment to facilitate interoperability with other telemedicine equipment and systems. In addition, where feasible, systems should be able to link to other telemedicine systems outside of the OAT-funded network (i.e., to out-of-network sites).

Telemedicine systems should be designed using the least costly, most efficient technology to meet the identified need(s). This may require that a network use different technologies at different sites, basing the choice on the needs of those to be served at the site and factoring in sustainability. For example, a network might place higher-end video-conferencing equipment at some sites within the network and use technology that enables two-way audio with transmission of still images at other sites; or a network may employ a web-based system at some sites; or a network might choose to deploy only one type of technology across all its sites, choosing a level that meets most needs and is sustainable.

The OAT believes that telemedicine networks are at a stage of development where providers should be using protocols to guide the delivery of clinical services using telemedicine. A protocol should describe how a service is to be provided, including what staff are to be present, how patients should be prepared for the consult, tests that should be ordered, etc. A protocol should be available for **each** telemedicine service provided (e.g., pediatric cardiology, speech therapy, dermatology), and for **both** the hub and spoke sites for each service. OAT grant recipients will be expected, during the first nine months of the first budget period, to develop a protocol for each service that they will provide with OAT funds in the first year. The protocols developed will be submitted with the Year 2 non-competing continuation application, which is due in the ninth month of the first year. If applicants from existing telemedicine networks have developed protocols, the protocols should be submitted as appendices to the application.

## Data Collection and Evaluation

As a condition of accepting funding from OAT, the grant recipient and its telemedicine network members will be **required** to participate in an OAT telemedicine data collection/evaluation effort. At a minimum, this will involve using a telemedicine log provided by OAT and OAT data collection/evaluation instruments. The OAT-sponsored data collection/evaluation activities will be subject to the Office of Management and Budget (OMB) approval under the Paperwork Reduction Act of 1995 and designed to meet the requirements of the Government Performance Review Act (GPRA).

In addition, as part of this application, an applicant is required to submit an evaluation plan that addresses not only how the telemedicine services data will be collected and analyzed, but also how the management of the project will be monitored and evaluated.

## Strategic/Financial Planning Documents

Each grant recipient will be required to submit a set of strategic/financial planning documents. The purpose of these strategic/financial planning documents is to demonstrate that the grantee, and each individual telemedicine site which receives OAT funds, has thought through the implications of sustaining the program after OAT funding ends and is committed to maintaining the program post-OAT funding.

Each grant recipient will be required to submit an initial strategic/financial planning document as part of the Year 2 non-competing continuation application, which is **due the ninth month of the first year**. The initial document will consist of two parts; (1) a separate telemedicine strategic/financial planning document prepared by the grantee/hub entity receiving OAT funds; and (2) an overall network plan prepared by the grantee.

**(1) Grantee Entity (Hub Site) Strategic/Financial Plan:** A separate telemedicine strategic/financial plan is to be prepared by the grantee entity. It should address, at a minimum, the current and future scope of the site's telemedicine program; the rationale for and the goals and objectives of the site's telemedicine program; any weaknesses in and threats to the site's telemedicine program; and the site's plans for overcoming such weaknesses and threats. In addition, the strategic/financial planning document will be required to include a detailed financial analysis - including 5-year forward-looking financial projections - of the telemedicine program, that demonstrates an awareness and understanding of potential revenue sources, expenses (including capital and operating costs and potential network fees), and cost savings.

**(2) Network Plan:** In addition to its own individual strategic/financial planning document, the grantee will be required to prepare and submit an overall network plan. This plan would include all sites in the network – i.e., both OAT-funded and non-OAT funded. This network plan would provide an overall description of the network and its operations, including the relationship of each individual site (including the grantee) to the network, and the responsibilities of the individual sites and the network to each other. The network plan will be expected to include an initial discussion of how the spoke sites anticipate addressing sustainability issues and activities. In this regard, it will be the responsibility of the grantee to insure that, over the course of the 3-year grant period, the plans, goals, objectives, and assumptions (both strategic and financial) of the individual sites are consistent with the plans, goals, objectives, and assumptions (both strategic and financial) of the grantee and of the network. No separate network financial information will be required as part of

the network plan. Rather, network financial information should be included in the individual plans and financial projections of the grantee (or other site that incurs and is responsible for such costs).

For the second phase of the strategic/financial planning activity, each grant recipient will be required to submit: (1) a separate telemedicine strategic/financial plan prepared by each individual spoke site receiving or to receive OAT funding; (2) an updated grantee/hub strategic/financial plan; and (3) an updated, comprehensive overall network plan prepared by the grantee. This second set of documents will be due in December of Year 2.

While it is anticipated that for the second phase, each individual site will prepare its own telemedicine strategic/financial plan, it will be the responsibility of the grantee – as the recipient of OAT funds – to ensure that each plan prepared by a site is completed and submitted in a timely fashion. Accordingly, it is anticipated that the grantee will play an active role in assisting the individual sites in the preparation of their plans and accompanying financial projections, and in reviewing the plans and financial projects for quality, completeness, commitment and sustainability. The applicant should note that developing the set of strategic/ financial documents is a time-intensive process for both the hub and spoke sites, and that at the spoke site, it will require the time of the administrator and/or the chief financial officer, as well as that of a site coordinator. This should be reflected in allocation of hub and spoke personnel in the budget.

### **OAT PROGRAMMATIC INTERESTS**

When designing a telemedicine network, an applicant should address the specific needs of the community(ies) to be served by the network. OAT is particularly interested in projects that propose:

- a) integrating public health clinics and public health department activities into the telemedicine program.
- b) providing telemedicine services in community-based locations such as the home, mental health centers, assisted-living facilities, senior citizen housing, schools, centers for the developmentally disabled, in addition to providing telemedicine services in clinics and hospitals.
- c) using telemedicine systems to improve access and coordination of health care services/case management.
- d) using telemedicine systems to enhance access to services for special populations across a range of settings in their own communities such as the elderly, children with special health care needs, and individuals with developmental disabilities, HIV/AIDS, or with neurological impairments (e.g., spinal cord injuries, multiple sclerosis, strokes and traumatic brain injury).
- e) coordinating the use of telemedicine systems with the activities of other HRSA-funded programs such as health professions programs (e.g., Area Health Education Centers, Rural Interdisciplinary Training Projects); maternal and child health programs (e.g., programs addressing emergency medical services for children, traumatic brain injury, children with special health care needs, or State child health insurance programs [CHIP]); HIV/AIDS programs; and primary care programs (e.g., community and migrant health centers and the National Health Service Corps).

- f) using telemedicine systems to enhance access to care in sparsely populated or frontier areas, along the U.S.-Mexico border, and in the Pacific Basin.
- g) using the telemedicine system to supervise/precept medical residents and other health professions students for clinical care at rural sites. OAT believes that telemedicine systems can facilitate the use of rural facilities for clinical training of health professions students and that clinical training in rural communities increases the likelihood that the health professional will practice in a rural community after graduation. Moreover, by strengthening the ties of local practitioners to health professions schools, it may reduce isolation, help rural practitioners maintain their clinical skills, address recruitment and retention issues, and promote a greater appreciation and understanding of rural practice by urban practitioners and health professions faculty.

Applicants should note that the above list does not encompass all areas that could be of interest to OAT. Therefore, applicants are encouraged to think broadly and creatively about how to structure a telemedicine network to address community needs.

### **ELIGIBLE APPLICANTS**

A grant award will be made either (1) to an entity that is a health care provider and a member of an existing or proposed telemedicine network, or (2) to an entity that is a consortium of health care providers that are members of an existing or proposed telemedicine network. (see page 7 for Telemedicine Network Requirements) **The applicant must be a legal entity capable of receiving Federal grant funds.**

The grant recipient must be a public (non-federal) or a nonprofit private entity, located in either a rural or urban area. An eligible network may include for-profit entities so long as the applicant (i.e., grant recipient) is a nonprofit entity. The applicant cannot be operated by the Department of Defense, the Department of Veterans' Affairs, the Indian Health Service, or other Federal agencies. However, health facilities operated by a Federal agency may be members of the network. All spoke entities supported by this grant must be located in a rural area. Although a State or local correctional facility located in a rural area may be a spoke site, it cannot be one of the two required rural sites. (If such a site is part of the network, the applicant should note whether it is a federally-designated prison HPSA.).

### **STATUTORY FUNDING PREFERENCE**

The authorizing legislation establishes a funding preference for applicants whose network members include any of the following:

- a) a majority of the health care providers serving the area or region to be served by the network;
- b) any federally qualified health center, rural health clinic, and local public health department serving the area or region;
- c) outpatient mental health providers serving the area or region; or

- d) appropriate social service providers, such as agencies on aging, school systems, and providers under the Women, Infants, and Children (WIC) program, to improve access to and coordination of health.

For preference purposes, the following definitions apply:

"Health care providers" in 'element (a)' are institutions and/or facilities that provide health care.

"Federally Qualified Health Centers" are defined as those federally and nonfederally-funded health centers that have status as federally-qualified health centers under section 1861(aa)(4) or section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(4) and 1396(l)(2)(B), respectively).

"Rural Health Clinics (RHC)" are defined as clinics certified by HCFA and approved to participate in the Medicare and Medicaid programs and receive payments as a Rural Health Clinic as defined under section 1861(aa) or 1905(l) of the Social Security Act (42 U.S.C. 1395x(aa) and 1395d(l), respectively).

Approved applications that qualify for the statutory funding preference will be funded ahead of other approved applications.

The HRSA will consider geographic coverage when deciding which approved applications to fund. In addition, HRSA is concerned with assuring that grants to new networks, as well as to existing networks, be funded. Therefore, when making awards, HRSA will consider the balance between grants to new telemedicine networks and to existing telemedicine network.

## **REVIEW PROCESS AND CRITERIA**

### **Review Process**

Competing applications are initially reviewed by staff for completeness and compliance with grant policies. Applications judged non-responsive because they are incomplete, improperly formatted, longer than the specified page limit, inadequately developed, or otherwise unsuitable for peer review and funding consideration, will be returned without further consideration. All responsive grant applications will be reviewed by an Objective Review Committee panel according to the criteria listed below. These reviewers score the proposal and provide a critique of the proposal to the Director, Office for the Advancement of Telehealth. The Director makes the final decision regarding funding.

### **Review Criteria**

Grant applications will be evaluated on the basis of the following criteria. Each criterion is followed by questions to assist the applicant with preparing the application. However, the narrative should not be limited to these questions -- the applicant should expand the discussion beyond these elements and demonstrate a thorough understanding of the content area.

**1) 20 points    Extent to which the applicant has documented the need for the project and the likely demand for the proposed services; developed measurable project objectives for meeting the need and demand; and developed a methodology or plan of activities that will lead to attaining the project objectives, including a plan to monitor the performance of the project and make improvements as needed.**

Is the applicant's perception of the need and demand supported by factual information/data? To document the need, does the applicant provide current health status and health services data for the rural communities to be served (i.e., data that are five years old or less, if available)? Does the applicant discuss and document current access to specialty services, rehabilitation services, home health services, etc., including services that are available locally from visiting specialists, including competitors? Does the applicant discuss issues of practitioner isolation and recruitment/retention? What additional types of data does the applicant utilize to document need?

Do the project objectives relate directly to the identified needs? Are the proposed objectives measurable, outcome oriented, time-limited and achievable?

Are the expected outcomes for each objective described using qualitative and quantitative measures? Are they carefully thought through in terms of both potential beneficial and adverse consequences?

Will the proposed activities lead to attaining the project objectives?

Is there a work plan for the project? Is it realistic? Does it specify who is responsible for each activity and provide a timeline for the activity?

Does the applicant discuss the process that will be used to monitor the performance of the project to make corrections and improve performance? Does the applicant discuss the approaches it will use to determine whether the objectives and outcomes described are met?

**2) 35 points    Extent to which the project objectives and related activities are consistent with the goal and objectives of the grant program (see Program Purpose on page 1).**

**a) 20 points    Extent to which the proposed project will increase access to health services, decrease practitioner isolation, and foster an integrated system of care.**

Is there a signed, dated memorandum of agreement that specifies the role and contributions of each member in the network? Did each member have an active role in planning the telemedicine network project? Does it show cost-participation by each OAT-funded member, including in-kind contributions, monetary contributions necessary for network sustainability, etc? Does it specify who will be responsible for any equipment funded with OAT dollars at the end of the project period (i.e., who will be responsible for equipment maintenance and upgrading, who will make decisions about equipment placement, etc.)? Does the applicant document current referral patterns, including both referral patterns among the network members and referral patterns that extend beyond network members?

Does the applicant discuss how telemedicine will strengthen and build upon existing relationships? Does the applicant describe how its proposed activities relate to rural health planning activities taking place under the State's Rural Hospital Flexibility Program award?

Does the applicant discuss whether other networking activities, in addition to the telemedicine network development, are underway to build an integrated, comprehensive rural health network? Is there documentation of past relationships and joint activities of network members?

Will the proposed telemedicine network encourage the coordination of services? Will it foster the efficient, effective delivery of services between rural facilities and a multi-specialty entity(ies), and within a rural community and among rural communities?

Does the applicant propose providing at least eight clinical services? Are at least two of the services provided by physicians? Does the applicant propose to utilize health professionals from a variety of disciplines (e.g., medicine, rehabilitation, nursing, mental health, etc.) to provide clinical services?

**b) 15 points    Extent to which the proposed project will provide a baseline of information and data for the systematic evaluation of telemedicine.**

Does the proposal discuss the specific data elements the applicant plans to collect? the specific data collection strategies and tools to be used? the types of analyses to be done on the data?

What resources, including resources at the rural sites (e.g., personnel, training time, funds) will be devoted to these evaluation activities? Do the resources appear adequate?

Has the applicant participated in other evaluations?

Given the data to be collected and the resources and experience noted, will the applicant be able to collect and provide data on costs (start-up and operating costs), utilization (for each type of specialty service provided), demand, patient and practitioner satisfaction, and network organizational factors such as staffing, administration, etc.?

Do the memorandums of agreement and letters of support acknowledge the evaluation activities that network members will be expected to participate in, including participating in an OAT-sponsored telemedicine data collection/evaluation?

**3) 20 points    Demonstrated capability, experience and knowledge (i.e. managerial, technical, and clinical) of the applicant and other network members to implement the project and to disseminate information about the project.**

Who will manage the project? What are her/his qualifications to manage the project? Who else will have responsibility for implementing the project at each site? What are the qualifications of these individuals?

Who will provide the clinical consultations? What are their qualifications? Is the relationship between the applicant and the clinicians who are to provide consultant services clarified (e.g., are the clinicians employees of the consultant? are they part of an autonomous group practice with privileges at the multi-specialty entity? etc.)

Are assurances provided (e.g. a signed, dated memorandum of agreement [MOA] as to how the services will be provided and by whom)? Does the MOA specify that services will be available on a 24-hour-a-day basis? Are assurances provided that the rural health professionals who are expected to use the telemedicine system to refer patients and/or for consultations/sessions are willing to do so?

Does the applicant discuss how telemedicine will be incorporated into clinicians' practices at both the hub and spoke? Are adequate resources (money, release time for training, etc.) proposed for training practitioners and site coordinators in the use of the technology? Does the applicant describe how clinician champions will be identified and utilized within the program?

Does the applicant provide an overview of the telemedicine system to be deployed and discuss in specific terms the equipment, software, network and telecommunication services that will be used? Is the type of equipment to be placed at each site identified? Is the type of transmission service to be used at each site identified (e.g., T1, fractional T1, ISDN) and mode of transmission (satellite, microwave, cellular, landline, etc.)? If the type of transmission service to be used at a site is not currently available, does the applicant provide **a written assurance** from the telecommunications carrier(s) as to the approximate date it will be available?

Does the applicant propose to use the least costly, most efficient technologies to meet the identified need? Does the applicant discuss the technological alternatives that it examined and provide a rationale for choosing the approach it selected? Does the applicant note the criteria it used in select the technologies -- e.g., basing equipment and/or transmission choice on type of service to be offered, sustainable transmission rates, ease of integration into clinician practice, ability for diverse applications across a range of community users, etc.

Does the applicant demonstrate familiarity with other telemedicine projects and activities in its region and state(s)? Does the applicant demonstrate familiarity with current telemedicine literature and networks in terms of identifying problems frequently encountered in telemedicine network development and proposing activities that address these problems? Does the applicant demonstrate familiarity with other barriers to telemedicine deployment (e.g., reimbursement) and discuss how it will address them?

How does the applicant propose to assure the privacy of patients and clinicians using the system and the confidentiality of information transmitted via the system (e.g., does the applicant propose to undertake staff education and to develop usage guidelines to deter improper use)? Does the applicant discuss how it is meeting Federal and State privacy and confidentiality guidelines?

Is there a plan for disseminating information about the project including "lessons learned," such as writing papers for submission to journals, speaking at conferences and workshops, providing information via a Web site, etc.?

Are adequate resources devoted to the activity and will individuals from the spoke sites as well as the hub sites be involved in the dissemination activities?

Does the applicant provide a strategy for marketing the program on an ongoing basis to rural providers and communities and to consulting professionals?

**4) 15 points    Level of local involvement in defining needs and planning and implementing the project. Level of commitment to the project as evidenced by cost participation by the applicant, other network members and/or other organizations, and realistic plans to sustain the telemedicine network after federal grant support ends.**

Were the local communities to be served by the telemedicine network involved in identifying the needs to be addressed? prioritizing the services to be provided? planning of the project? What evidence of involvement is provided? Does the proposal discuss the decision-making process for the network and describe how the role of rural members will be fostered in the governance and decision-making process?

Is there evidence of support for the project from community leaders, state officials, local organizations, and others who have the ability to facilitate and contribute to the implementation of the project?

Are there letters of support/commitment to participate from hospital and/or clinic boards and do such letters enumerate the level of support?

What costs are being contributed to the project? By whom? Is there a long-term commitment to the project, beyond the 3-year funding cycle, by each network member? By what means is the applicant proposing to sustain the project after federal funding ends? Is the proposal reasonable? Does the proposal take into account what is currently recognized about telemedicine network sustainability? Does it take into account the level of technology chosen and its associated transmission costs? Does it describe a variety of revenue sources and support to be developed to sustain the network?

**5) 10 points    Relevance of the budget to the proposed activities and reasonableness of the budget to anticipated outcomes/results.**

Are the needs for equipment, supplies, contractual services, and other budget items adequately justified in terms of the goal(s), objectives and proposed activities of the project?

Are the projected costs to the Federal government reasonable considering the level of services to be provided and anticipated outcomes/results?

Does the budget conform to the use of grant dollars permitted by the grant program?

## QUESTIONS AND ANSWERS

**1. What are the objectives of the Rural Telemedicine Grant Program?**

The primary objective of the program is to demonstrate how telemedicine can be used as a tool to a) increase access to health care, b) reduce practitioner isolation, and c) foster integrated systems of care. A secondary objective is to develop a base of information for the systematic evaluation of telemedicine systems serving rural areas.

**2. How many new grants will be awarded for FY 2000 and for how much?**

Twelve to fifteen grants will be awarded. Grant awards to new networks are limited to \$375,000 (including direct and indirect costs) per year; grant awards to existing networks are limited to \$325,000. It is anticipated that an existing telemedicine network would already, at a minimum, have equipment and be supporting some hub-site personnel. Overall, applications for smaller amounts are strongly encouraged.

**3. What will be the length of the grant award?**

Budget periods will be for 12 months. An applicant should propose a three year project period. Funding after the first year will be contingent upon the availability of funds in subsequent years and performance.

**4. What is the schedule for making the awards?**

Applications are due March 15, 2000. Awards will be made by August 31, 2000.

**5. What are the qualifications an organization must have to receive a grant?**

To receive a grant, an organization must be (1) a health care provider and a member of an existing or proposed telemedicine network **or** (2) a consortium of health care providers that are members of an existing or proposed telemedicine network (see questions 10 and 11). The grantee may be located in either a rural or urban area. It may be public (non-federal) entity or a nonprofit entity. Rural spoke sites may be public or private entities, either nonprofit or for-profit.

**6. Are there geographic limits on the scope of the grant projects?**

All grant-supported health care services delivered over the telemedicine system must be provided to individuals in rural areas. Telemedicine networks may cross state or county lines, or jurisdiction lines in the case of Puerto Rico, the Virgin Islands, the Pacific Basin flag territories and freely-associated states.

**7. Will there be geographic considerations in the decisions for awards?**

Geographic coverage will be considered when deciding which approved applications to fund. In addition, the balance between awards to new telemedicine networks and to existing telemedicine networks will be considered.

**8. Is there a limit on the amount of funding that can be used for indirect costs?**

Yes. In accordance with the law, no more than 20 percent of the amount provided under a grant can be used to pay for the indirect costs associated with carrying out the purposes of the grant. The applicant must provide a copy of its most recent Negotiated Indirect Cost Agreement with a cognizant Federal agency; the agreement must contain a "services" or "all other programs" rate or the intention to negotiate such a rate with the responsible officials in a timely manner. A rate negotiated for research programs is not acceptable. Applicants are reminded that indirect costs can be contributed as part of cost participation.

**9. Are there any other funding limitations?**

Yes. No more than 40 percent of the grant dollars can be spent to purchase, lease or install equipment, and of this 40 percent, no more than 35 percent or \$50,000 (whichever is higher) can be spent for equipment whose sole use is teleradiology. Grant funds may not be used to purchase transmission equipment, such as microwave towers, digital switching equipment, etc. Grant dollars may not be used for construction except for minor renovations related to the installation of equipment. The grant may not be used to acquire or build real property. All the funding must be used to provide services to rural communities. At least 50% of the grant dollars must be spent for: transmission costs and clinician incentive payments; costs incurred in rural communities, including rural staff salaries and equipment maintenance; and equipment placed in rural communities, irrespective of where the equipment was purchased. Grant dollars may not be used to support didactic distance education activities, although equipment purchased to provide clinical services can be used for a variety of non-clinical purposes, including didactic education, administrative meetings, etc. Grant dollars may not be used to cover the transmission costs or clinician incentive payments of out-of-network sessions.

**10. Who can be members of the telemedicine network?**

The telemedicine network must include a multi-specialty entity (hub) and at least two rural health facilities (spokes), which may include rural hospitals (fewer than 100 staffed beds), rural physician offices, rural health clinics, rural community health clinics and rural nursing homes.

In addition to the required rural health facilities, OAT is particularly interested in projects that include sites such as mental health centers, public health clinics, schools, homes, assisted living facilities, senior citizen housing, centers for the developmentally disabled, etc. Health facilities operated by a Federal agency may be members of the network, but cannot be the applicant.

A network may have additional members who do not directly receive or provide consultations, but who foster access to and coordination of services, such as area agencies on aging, school systems, providers under the WIC program, etc.

All spoke entities supported by this grant must be located in a rural area. Urban spoke sites may be members of the network, but services to those sites cannot be supported by this grant.

**11. Have funding preferences or priorities been established?**

The authorizing legislation establishes a funding preference for applicants whose network includes: a) a majority of the health care providers serving in the rural area or region to be served by the network; b) any federally qualified health centers, certified rural health clinics (P.L. 95-210) and local public health departments serving in the rural area or region; c) outpatient mental health providers serving in the rural area or region; or d) appropriate social service providers, such as agencies on aging, school systems, and providers under the Women, Infants and Children (WIC) program to improve access to and coordination of health care services.

Approved applications that qualify for a statutory funding preference will be funded ahead of other approved applications.

If an applicant claims a preference on the basis that the telemedicine network includes a majority of the providers in the area to be served by the network (element 'a'), OAT will ask the applicant's State Office of Rural Health to help OAT evaluate the claim.

**12. Should the members of the telemedicine network establish themselves as one legal entity?**

No. There is no need for the network to establish itself as a single legal entity. However, there must be a strong plan developed for how the network will be managed, and each member must have a specific role and contribute resources toward the project. There also must be assurances, preferably in the form of signed, dated agreements, that eight clinical services, will be available to the rural communities served by the project.

**13. If we have a signed, dated memorandum of agreement that describes each member's roles and responsibilities in the telemedicine network, do we need to also have letters of support from the network members?**

It is advisable to submit both a formal agreement and letters of support. A signed agreement among the network members is important for describing each member's role in the network and the resources they have agreed to commit to the project. Letters of support from the network members and involved communities provide an additional opportunity for the network members and communities to independently convey their support and enthusiasm for the project. The agreement should stipulate the arrangement concerning equipment placement, maintenance and stewardship once OAT grant funding ends. In addition, an agreement should spell out a spoke site's contribution to the telemedicine network, including not only in-kind contributions, but also any monetary contributions for network sustainability.

**14. What are the required clinical services?**

The applicant must propose to provide at least eight clinical telemedicine services. Not all services need be provided to all sites or across all age groups. At least two of the services must be implemented by the end of the first project year; an additional three by the end of the second year; and the remaining three by the middle of the third year.

The applicant, in consultation with the network members, should select the services to be provided by the telemedicine network. The decision should be based upon well-documented community need and demand (e.g., services that are not available locally, services that rural residents may forego if they have to travel far or often for them, etc.). At least two of the eight services provided by the network with OAT funding must be services provided by physicians.

**15. Would a project that proposes only to address a specific population group (e.g., children with special health care needs or the elderly) be eligible for funding?**

It is expected that projects will be designed to provide services to **individuals across the life-span**. Therefore, a project that proposes only to provide services to a limited population group would not be competitive. However, as one component of a larger set of activities, an applicant may propose providing services to specific populations such as children with special health care needs, or elderly in an assisted living facility, or individuals with AIDS in home or hospice settings.

**16. Should the applicant provide assurances that the required specialty services will be provided on a 24-hour a day basis to the rural sites served by the network?**

Yes (see review criterion #3 -- "demonstrated capability ... of the applicant to implement the project"). Applicants that are multi-specialty entities should include signed, dated memorandums of agreement or letters of commitment from their specialty departments, assuring that the specialty services will be available to the rural sites served by the network on a 24-hour-a-day basis. If some of the clinicians who are to provide services for the multi-specialty entity are not employees of the entity, the applicant should submit signed memorandums of agreement or letters of commitment from these clinicians or their practice groups. Applicants which themselves are not multi-specialty entities are strongly encouraged to have signed contracts with the multi-specialty member(s) of the network, assuring that the specialty services will be available to the rural sites on a 24-hour-a-day basis.

If the applicant is proposing to provide any service on less than a 24-hour basis, the applicant must provide a justification for doing so. OAT recognizes some services (e.g., physical therapy or speech therapy) are not typically provided on a 24-hour basis.

**17. How soon after the award is made should the telemedicine system be operational?**

This is not a planning grant. Grantees should be prepared to move forward with their project (i.e. hire personnel, purchase and install equipment, etc.) as soon as an award is made. Grantees should be able to provide all eight services by the sixth month of the third year. At

least two of the eight services must be provided by the end of the first year, an additional three by the end of the second year, and the final three by the sixth month of the third year.

## **INFORMATION REQUIREMENTS ASSURANCES AND PUBLIC POLICY REQUIREMENTS**

Applicants are required to sign certain certifications and assurances as part of the application process. Some of these are briefly described below. Complete descriptions and lists are included in the application kit.

### **Debarment and Suspension**

The applicant organization must certify, among other things, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency. Subawardees, that is other corporations, partnerships, or other legal entities (called "lower tier" participants), must make the same certification to the applicant organization concerning their covered transactions. The pertinent DHHS regulations are found in 45 CFR part 76.

### **Drug-Free Workplace**

The Drug-Free Workplace requires the authorized representative to certify that the applicant organization will, or will continue to provide a drug-free workplace. The certification includes employees of the applicant organization and any "lower tier" participants. The applicant organization must publish information regarding the legal implications for drug manufacture, distribution, dispensing, possession or use of a controlled substance in the workplace; establish an on-going drug-free awareness program to inform employees; provide a copy of this information to employees engaged in grant-related activities; and other requirements.

### **Certification Regarding Lobbying and Disclosure of Lobbying Activities**

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain federal contracting and financial transactions," generally prohibits recipients of federal grants and cooperative agreements from using federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. It also requires that this certification be included in the award documents for all "lower tier" participants, including subcontracts, network members, and contracts under grants, and cooperative agreements, and that all subrecipients shall certify and disclose accordingly. These requirements apply to all grants and cooperative agreements that exceed \$100,000 in total costs.

### **Certification Regarding Program Fraud Civil Remedies Act (PFCRA)**

Certification is required that all information in the application is true, complete, and accurate and that the authorized representative signing for the applicant organization is aware that any false, fictitious, or fraudulent statements or claims may subject the signer to criminal, civil, or administrative penalties. Certification also includes an agreement to comply with the terms and conditions of the award if the proposed project is funded.

### **Certification Regarding Environmental Tobacco Smoke**

The applicant is required to certify that it will comply with the requirements of the Pro-Children Act of 1994 (Public Law 103-227). The Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee.

### **Assurance of Organizational Capability**

The applicant organization certifies its ability to apply for federal assistance, and that it has the institutional, managerial, and financial capability to ensure proper planning, management, and completion of the project described in the application.

### **Assurance of Compliance with Nondiscrimination Statutes**

The applicant organization provides assurance that it will comply with the following nondiscrimination statutes:

Title VI of the Civil Rights Act of 1964 (P.L.. 88-352) prohibits discrimination on the basis of race, color, or national origin.

Title IX of the Education Amendments of 1972, as amended, prohibits discrimination on the basis of gender.

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits discrimination on the basis of handicaps.

The Age Discrimination Act of 1975, as amended, prohibits discrimination on the basis of age.

The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L.. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

The Public Health Service Act of 1912, as amended, relating to confidentiality of alcohol and drug abuse patient records.

Title VIII of the Civil Rights Act of 1968, as amended, relating to nondiscrimination in the sale, rental, or financing of housing, and any other nondiscrimination provisions in the specific statute(s) under which federal assistance is being made, and requirements of any other nondiscrimination statute(s) which may apply to the application.

## **REPORTS**

An audit must be completed in accordance with the audit requirements indicated on the Notice of Grant Award. Depending on the type of organization, this will be A-133 (Educational Organizations and Private non-profits), A-128 (State and Local Governments and Indian Tribes) or GAO Yellow Book of 1988 (Hospitals).

### **Annual Program Performance Report**

The annual program performance report documents progress. This report is part of the non-competing continuation application and is required to assure continued grant support. Instructions for preparing and submitting this report will be included in the non-competing continuation application kit. This application kit will be automatically sent to grantees.

### **Financial Status Report**

A financial status report is required within 90 days after the end of each budget period. A final accounting of expenditures is required within 90 days after the end of the project period. The final financial status report must show no unliquidated obligations and must indicate the exact balance of unobligated funds.

### **Final Program Performance Report**

A final report must be submitted within 90 days of the end of the project period. Materials and instructions for preparing and submitting this report will be sent to the grantee by the Grants Management Officer approximately 90 days prior to the termination of the project.